Report of the AUGIS Travelling Fellowships 2012

Visit to the Cancer Institute Hospital of Japanese Foundation For Cancer Research, Tokyo, Japan, April 2013

Ms Naheed Farooq, Senior Clinical Fellow, Oesophagogastric surgery department, Addenbrookes Hospital, Cambridge University Hospitals NHS Foundation Trust

The Cancer Institute Hospital of Japanese Foundation For Cancer Research is a modern facility located in Ariake, Koto, Tokyo. The building has been erected on reclaimed land affording scenic views of Tokyo Bay. Its proximity to the coast exposed one to a windy and chillier than expected climate for Spring in Tokyo, however the weather did not detract from what was still a fantastic surgical and cultural experience.

On the first “working” day of my visit in mid April, I was met by Professor Takeshi Sano in the foyer of the Cancer Institute Hospital. As a pioneering surgeon of radical gastric cancer surgery, he directs the Gastroenterological surgery department which comprises 4 gastric surgeons, 2 oesophageal surgeons, as well as a number of colorectal and hepatobiliary surgeons.

The department performed 600 gastric resections in the last year, two thirds of these laparoscopically, a reflection of the success of the national screening programme that is able to pick up a large number of early gastric cancers (EGCs).

The department has regular case conferences attended by all junior and senior surgeons. The pre and post-operative patients are discussed with their staging and pathology.
In stark contrast to the UK there is a dearth of oncologists and radiologist at these meetings. Neoadjuvant chemotherapy does not feature in the treatment algorithm for managing patients with potentially curable gastric cancer. Patients with stage II & III disease are considered for adjuvant chemotherapy.

Among the other longstanding differences between East and West has been that the majority of Japanese patients are slim and their cancers tended to be located in the distal stomach. More recently however a gradual change has been noticed; obesity is on the rise in Japan and increased numbers of proximal gastric cancers are being found. This phenomenon has been coined “Westernisation of Gastric cancer” by the eminent Professor Sano, who feels this is related to eradication process of Helicobacter pylori from the general population.

Surgery is performed mainly by senior surgeons but there is a structured training programme in place for the very dedicated surgical residents, omnipresent in theatre.

The HD laparoscopic stacks afford excellent videography of the laparoscopic surgery and even the open operations were possible to view for those steady on their feet.

On a standard day 2 to 3 gastrectomies were performed. Everything in Japan usually runs strictly to time, trains are never a minute late, the operating theatres however conformed to no such schedules. Cases would take as long as was necessary and nobody quibbled about over-runs, despite these occurring on a regular basis by most surgeons. The relief of not having to rush through a difficult anastomosis for fear of cancellations and consequences allowed the surgeons adequate time to perform a meticulous lymphadenectomy both open and laparoscopically.
Scrubbed for D2 total gastrectomy & splenectomy, T.Chiba (surgical resident), N.Farooq, Takeshi Sano.

Open surgery was the preferred approach for all clinically node positive cancers and advanced tumours. For T1 tumours, of which there were comparatively high numbers the surgery was more novel. For early distal tumours a laparoscopic Billroth 1 was performed. For lesions in the mid stomach, a laparoscopic pylorus preserving gastrectomy was often carried out. Whilst for small early proximal tumours a laparoscopic proximal gastrectomy was performed.

The specimen would be processed by the residents who were responsible for labelling individual nodal stations and entering the data into the database.

These databases help provide raw material for many of the ongoing research projects actively being carried out in this busy institution.

The volume of work carried out in this Japanese cancer centre cannot be rivalled by any centre in the UK. Seeing the confidence, skill and adeptness demonstrated by these surgeons both laparoscopically and in
open surgery clearly re-enforced the idea that working in a large volume centre is advantageous for surgeons and patients.

The Japanese have for many years been masters of the D2 gastrectomy but with the growing Westernisation of gastric cancer in Japan could we in the UK who are accustomed to dealing with advanced proximal cancers in an obese patients have finally found one aspect of gastric cancer surgery that we could offer advise upon.....

For so many reasons my experience in Japan has been invaluable and I am grateful to AUGIS for making this trip possible.

Ms Naheed Farooq